[*We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requester*.]

Date Issued: **May 3, 2001**

Date Posted: **May __, 2001**

[name and address redacted]

Re: OIG Advisory Opinion No. 01-03

Dear [name redacted]:

We are writing in response to your request for an advisory opinion as to whether proposed contracts for discounted services between the [name redacted], a Federally-recognized Indian tribe, and local hospitals (the "Proposed Arrangement") would constitute grounds for the imposition of sanctions under the exclusion authority at section 1128(b)(7) of the Social Security Act (the "Act") or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act.

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement would potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, but that the Office of Inspector General ("OIG") would not impose administrative sanctions on the [name of tribe redacted], under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement.

This opinion may not be relied on by any persons other than the [name of tribe redacted], and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

The [name of tribe redacted], also known as [name redacted] (the "Tribe"), is a Federally-recognized Indian tribe located in [city, county, state redacted]. The Tribe is a sovereign Indian nation retaining the right of self-government over its members and territory, subject to the authority of Congress. The Tribe has been designated as a Federally-recognized Health Professional Shortage Area, and [name of town], in [name of county], has been designated as a medically underserved area.

Pursuant to the Indian Self-Determination and Education Assistance Act of 1975, Pub. L. No. 93-638 (the "Self-Determination Act"), the Tribe has entered into a self-determination agreement with the Indian Health Service ("IHS")[1] under which the Tribe receives Federal funds from the IHS to provide Tribe members with health care services that would otherwise be provided by the IHS.[2]

The Tribe owns and operates the [name of tribe redacted] Health Center (the "Health Center"), where it provides primary health care services to approximately 1500 Tribe members and dependents,[3] as well as approximately 540 Tribe employees.[4] The Health

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[1]IHS is an agency of the Public Health Service within the Department of Health and Human Services tasked with assuring that basic health care is available to Indian people. Persons eligible for IHS services include members of Federally-recognized Indian tribes; certain individuals under the age of nineteen who are natural or adopted children, step-children, foster children, legal wards, or orphans of an eligible Indian; and certain non-Indian spouses of Indians. 25 U.S.C. § 1680(c).

[2]The Self-Determination Act requires IHS to provide funds for health care programs and facilities operated by tribes and tribal organizations under self-determination contracts on the same basis as such funds are provided to programs and facilities operated directly by IHS. 25 U.S.C. § 1680a.

[3]Of these 1500 patients, 121 were Medicare beneficiaries (8%) and 227 were Medicaid beneficiaries (15%) in the most recent fiscal year.

[4]The employees are insured under the Tribe's self-funded employee group health plan. No IHS funds are used for benefits under the employee group health plan. Of the 540 employees, fewer than seventeen are Medicare beneficiaries for whom the Tribe is the secondary insurer.

Center is funded through IHS funds (approximately 43%), third party insurance reimbursements, including Medicare and Medicaid (approximately 43%), other tribal sources (approximately 11%), and the "[name redacted]" program, a state assistance program (approximately 3%).

For necessary services for eligible Tribe members and dependents not provided directly by the Health Center, such as specialty and hospital services, the IHS appropriates to the Tribe an annual, fixed sum pursuant to the IHS Contract Health Services program (the "CHS program"). CHS funds may be used to pay third parties to provide such services. The Tribe has experienced shortfalls of CHS funds for medically necessary specialty and hospital services in recent years. When CHS funds are not available, the Health Center applies for emergency funding from other sources, including the Federal Catastrophic Health Emergency Fund ("CHEF"), uses other funds, if available, or requires that the patient seek admission as a charity care patient.[5] To conserve CHS dollars, the IHS encourages tribes to be prudent purchasers of CHS-funded services through the negotiation of discounted rates with third party providers.

The CHS program serves as a supplemental payer for Tribe members and dependents who have other health insurance, such as employer-sponsored insurance or Medicare. See 42 C.F.R. § 36.61. Thus, for virtually all Tribe members and dependents who are Medicare beneficiaries, Medicare is the primary payer.[6] In addition, the law expressly exempts individuals eligible for CHS-funded services from any liability for charges or costs associated with such services, including applicable Medicare copayments and deductibles. See 25 U.S.C. § 1621u. In this regard, HCFA policy provides that "in the case of contract health services to Indians and their dependents entitled under the IHS program, Medicare will be the primary payer and the IHS the secondary payer." See Hospital Manual § 260.3B. Thus, the IHS or tribes operating under self-determination

[5]An OIG audit report concluded that in recent years, CHS funding has failed to keep pace with inflation, resulting in curtailed services to IHS beneficiaries. See "Review of the Indian Health Service's Contract Health Services Program," Office of Inspector General (A-15-97-50001). The audit report noted that in fiscal year 1995, the CHS program was unable to provide over 90,000 recommended or requested services; on occasion, medical care of the highest priority level was denied or deferred due to the shortage of funds.

[6]The exception may be certain employees for whom the Tribe's employer plan is primary and Medicare is secondary.

agreements act as the secondary payer for CHS-funded services.[7]

Under the Proposed Arrangement, the Tribe will enter into agreements with any willing local hospital pursuant to which the hospital will reduce by 10% its normal charges to the Tribe for hospital services provided to Health Center patients. For Medicare beneficiaries – for whom the Tribe's financial responsibility is limited to paying the Medicare copayment and deductible amounts – the hospital will reduce its copayment and deductible charges (hereafter, the "copayment") by 10% of the hospital's actual charge for the patient, resulting, in most cases, in a reduction of approximately 50% of the copayment amount.[8] The hospital will bill Medicare as the primary insurer according to its normal billing procedures and later bill the Tribe for any copayment amount.[9] The Tribe will not submit any claims to Medicare for hospital services provided under the Proposed Arrangement. Under the Proposed Arrangement, the hospital will not claim the waived portion of the copayment amounts as bad debt or otherwise shift the burden of nonpayment to other payers.

The Proposed Arrangement, in conjunction with applicable Federal laws and regulations, contains a number of safeguards against overutilization of CHS-funded services and increased Medicare program costs:

- Under the CHS program, tribes must allocate scarce CHS funds according to a medical priority system that targets urgent or emergent care. See 42 C.F.R. § 36.23(e). The CHS program further requires Tribe members to seek services from the Health Center, rather than an outside provider, whenever possible.

- The Health Center has established internal procedures to control utilization

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[7]Ordinarily, Medicare payment may not be made for items or services that neither the beneficiary nor any other person or organization has a legal obligation to pay. Nor is Medicare payment ordinarily made for items or services that a provider is obligated to furnish at public expense pursuant to an authorization issued by a Federal agency.

[8]Some Tribe members and dependents are eligible for Medicaid. Where Medicaid is the primary insurer, there are typically few, if any, copayment requirements. Under the Proposed Arrangement, for services provided to Medicaid-eligible beneficiaries, the hospitals will bill Medicaid in accordance with their customary billing procedures. The Tribe will not bill Medicaid for any hospital services under the Proposed Arrangement.

[9]We express no opinion as to the propriety of the billing by the hospitals.

of CHS-funded services. Patients may not obtain CHS-funded services without a signed referral from, or approved by, a full-time Health Center physician.[10] A separate referral form is required for each patient visit.[11]

- Neither of the Health Center's two full-time physicians has any financial relationship with any local hospitals, although one has staff privileges at one local hospital.

- Under the Proposed Arrangement, the contracting hospitals will not perform any non-emergent covered services for Health Center patients unless specifically authorized by a referral from the Health Center.

Patients may, but are not required to, obtain services from the contracting hospitals. They are free to obtain a referral to a hospital that is not a party to the Proposed Arrangement (subject to the rules governing pre-approval and prioritization of CHS funds).

II. LEGAL ANALYSIS

The anti-kickback statute makes it a criminal offense knowingly and wilfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce referrals of items or services paid for by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, in cash or in-kind, directly or indirectly, covertly or overtly.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain money for referral of services or to induce further referrals. United States v. Kats, 871 F. 2d 105 (9th Cir. 1989); United States v. Greber, 760 F. 2d 68 (3rd Cir.), cert. denied, 476 U.S. 988 (1985). Violation of the statute constitutes a felony

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[10]The Health Center has two full-time staff physicians and employs a part-time physician approximately one day per week. Referrals for CHS-funded services made by the part-time physician must be approved by a full-time Health Center physician.

[11]The patient submits a referral form to the CHS provider, who is thereby advised about the potential availability of CHS funds to pay for the services and the CHS rules for collection. In the absence of available CHS funds, the provider has no assurance of payment.

punishable by a maximum fine of $25,000, imprisonment up to five years or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. Where a party commits an act described in section 1128B(b) of the Act, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party under section 1128A(a)(7) of the Act. The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.

Although styled as a "discount," the Proposed Arrangement, as applied to Medicare services, is a routine waiver of part of the Medicare copayment. The routine waiver of all or a portion of the Medicare copayment is suspect under the anti-kickback statute.[12]

Notwithstanding, in the circumstances presented here, the OIG would not seek to impose administrative sanctions related to the anti-kickback statute for acts in connection with the Proposed Arrangement. First, the Federal government receives the full benefit of the discount under the Proposed Arrangement. Unlike the usual situation in which the copayment obligation is owed by either the beneficiary or the beneficiary's insurer, the Federal government through the IHS (or the Tribe on IHS's behalf) is responsible for copayments for the Tribe's Medicare beneficiaries. Because Medicare reimburses both Part A inpatient and Part B outpatient hospital services at fixed prices, there is no opportunity for Medicare to capture any part of the 10% discount offered to the Tribe under the Proposed Arrangement.[13] However, by applying the discount to the remaining copayment, which is also paid substantially with Federal funds, the Federal government's aggregate payment for the service is reduced by 10% – the same discount received by the Tribe for its non-Medicare patients. In short, although Medicare may not receive the benefit of the discount, the Federal fisc does.

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[12]See, e.g., Special Fraud Alert, 59 Fed. Reg. 65,372, 65,374 (published in the Federal Register on Dec. 19, 1994). Copayment waivers also potentially implicate section 1128A(a)(5) of the Act, the prohibition on inducements offered to Medicare and Medicaid beneficiaries. Because Tribe members have no statutory liability for Medicare or Medicaid copayments for CHS-funded services, section 1128A(a)(5) is not implicated here. Simply put, in these circumstances, the partial copayment waiver is not an inducement to the beneficiaries who have no obligation to pay it.

[13]This would not be the case if the discount arrangement involved Part B services, such as physician services, that are reimbursed on the basis of the lower of the provider's actual charges or a Medicare fee schedule amount. In such case, the discount could be allocated to the government's portion of the payment.

Second, the Proposed Arrangement will not result in unfair competition. The Tribe is willing, even eager, to enter into the Proposed Arrangement with any willing hospital provider. The fact that some hospitals may not wish to provide services for the discounted amount does not mean that the pricing arrangement is illegal or improper. Public policy favors open and legitimate price competition in the Medicare program so long as the savings are shared with the Federal government. See 1128B(b)(A) of the Act (exception for price reductions).

Third, there appears to be no substantial risk of "swapping." We have previously articulated our concern about discounts offered on non-Medicare business that are tied to, or conditioned on, referrals of Medicare patients for whom Medicare pays a higher, non-discounted rate. (See, e.g., OIG Advisory Opinions 99-2 and 99-13). Here, the number of Medicare beneficiaries among the Health Center's patients is relatively small in comparison to the total number of patients (approximately 138 out of 2040, or approximately 7%). Medicaid patients comprise an additional 15% of the patient pool. In the circumstances presented, there is little likelihood that a hospital will agree to discount approximately 75% of its business in order to secure these Medicare and Medicaid referrals. This is especially true where, as here, Medicare and Medicaid payment rates are in many cases lower than the Tribe's negotiated rate for a comparable service for a non-Federal patient.

Fourth, the Proposed Arrangement should not appreciably increase the risk of overutilization of services. Patients are only permitted to seek CHS-funded services at a hospital if such services are not available at the Health Center. Moreover, all non-emergent CHS-funded hospital services are subject to pre-authorization by a Health Center physician. Given the scarcity of CHS and other funds and the large number of Tribe patients with no outside insurance, the Tribe has significant financial incentives to control utilization of CHS services provided to Medicare patients.

Finally, the Proposed Arrangement arises in the context of the unique and historic relationship between the Federal government and the sovereign Indian nations, pursuant to which Congress has promulgated certain health care programs for the benefit of Indian people. As part of that relationship, Congress created the CHS program, deemed Medicare the primary payer for CHS-covered services for eligible Medicare beneficiaries, and exempted those beneficiaries from copayment liability. Instead, the IHS or the Indian tribes assume responsibility for paying the Medicare copayment amounts. The Proposed Arrangement is fully consistent with IHS policy encouraging tribes to be prudent purchasers of CHS-covered services.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement would potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, but that the OIG would not impose administrative sanctions on the [name of tribe redacted] under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to the [name of tribe redacted], the requester of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.

- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a requester to this opinion.

- This advisory opinion is applicable only to the statutory provisions specifically noted above in the first paragraph of this opinion. No opinion is herein expressed or implied with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to Proposed Arrangement.

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.

- This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those that appear similar in nature or scope.

- No opinion is expressed herein regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against the requester with respect to any action that is part of the Proposed Arrangement taken in good faith reliance upon this advisory opinion as long as all of the material facts have been fully, completely, and accurately presented, and the

Proposed Arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, rescind, modify, or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the requester with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented, and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion. An advisory opinion may be rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/s/

D. McCarty Thornton
Chief Counsel to the Inspector General